O'Neill Family DENTISTRY

Dr. Kris Hilton
3224 Millwood Ave.
Columbia, SC. 29205
(803)988-1070
Fax: (803)988-8436
Office@drkrismoneill.com

Dear New Patient,

On behalf of Dr. Kris Hilton and her team, we are delighted to welcome you to our practice. We are pleased that you have chosen us to care for your dental needs. We are committed to providing you with high quality dental care in a caring, gentle environment. Our patient's comfort is of the utmost importance to us!

At your appointment you can expect:

- A thorough examination and assessment of your oral health
- A preventative cleaning/x-rays, if necessary
- A careful evaluation of your dental status
- An oral cancer screening
- A discussion of the most satisfactory treatment plan to meet your oral needs

To assist you best and to expedite your appointment, please return the following items to our office **prior** to your appointment:

- Completed Patient Information Forms
- A copy of the front and back of your dental insurance card
- Release of Records form to transfer recent dental x-rays, if necessary

You can return these forms to us by mail, e-mail or fax.

We do require that any child under the age of 18 be accompanied by a parent or guardian.

We will do everything we can to guarantee your experience with our office is a positive one, therefore, if you have any comments or recommendations about your care here, please let us know. Thanks again for choosing our dental practice. We look forward to meeting you soon!

Sincerely,

Dr. Kris Hilton & Staff

Patient Information

Date: ____/____/_____

Name: First _____ Last_____ M__ SSN #_____

Preferred Name _____ Email _____

Address_____ City _____ State _____ Zip _____

Sex ___ M ___ F Age_____ Birthdate_____ DL#_____

Home # (___) _____Cell # (___) _____Work # (___) _____

Please Circle: Married Widowed Single Divorced Separated Minor Partner

New Patients: Who may we thank for referring you? _____

Person Responsible for Account: _____

Relationship to Patient _____ Birthdate _____ SSN _____

Primary Insurance:

Insurance Company _____ Subscriber ID _____

Ins Co Address _____ City _____

State _____ Zip _____ Group Number _____

Policy Holder Information: Name: _____ Birthdate _____

Employer: _____ Relationship to Patient _____ Ph: _____

Address (If different from patient) _____

Secondary Insurance:

Insurance Company _____ Subscriber ID _____

Ins Co Address _____ City _____

State _____ Zip _____ Group Number _____

Policy Holder Information: Name: _____ Birthdate _____

Employer: _____ Relationship to Patient _____ Ph: _____

Address (If different from patient) _____

Authorization:

I certify that I, and/or my dependent(s), have the above dental coverage. I understand that I am responsible for all charges for dental services that are not covered by my dental plan. I understand that the above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I hereby authorize the release of any information to my insurance company that is related to the dental services rendered by Kris M. Hilton.

_____ _____

Signature of Patient/ Parent/ Guardian or Authorized Representative — Date

_____ _____

Printed Name of Authorized Representative — Relationship/ Capacity to Patient

Name _____ **Birthdate** _____

Check if you have had any problems with the following:

__ Bad breath	__ Grinding teeth	__ Sensitivity to hot
__ Bleeding gums	__ Loose teeth or broken filling	__ Sensitivity to cold
__ Clicking/Popping Jaw	__ Periodontal treatment	__ Sensitivity to sweets
__ Food collection b/w teeth	__ Sores/growths in mouth	__ Sensitivity when biting

How often do you brush? _____ Do you use an electric toothbrush? YES NO

How often do you floss? _____ Do you use a waterpik? YES NO

Medical History:

Primary Care Physician: _____ Phone Number: _____

Date of Last Visit: _____ Preferred Pharmacy: _____

Please Circle YES or NO for the following:

Have you had a heart attack or stroke? YES NO Approx. Date: _____

Have you had a joint replacement? YES NO Approx. Date: _____

Have you had any serious illnesses or operations not listed above? YES NO

If yes, please describe: _____

Have you ever been told you need to be pre-medicated before dental treatment? YES NO

If yes, please describe: _____

WOMEN: Are you pregnant? YES NO Nursing? YES NO Birth Control? YES NO

Allergies_____

Check if you have any of the following:

__ Anemia	__ Cortisone Treatments	__ Hepatitis	__ Scarlet Fever
__ Arthritis, Rheumatism	__ Cough, Persistent	__ High Blood Pressure	__ Shortness of breath
__ Artificial Heart Valve	__ Cough up blood	__ High Cholesterol	__ Skin Rash
__ Artificial Joints	__ Diabetes	__ HIV/ AIDS	__ Stroke
__ Asthma	__ Epilepsy	__ Kidney Disease	__ Swelling
__ Back Problem	__ Fainting	__ Liver Disease	__ Thyroid Problem
__ Blood Disease	__ Glaucoma	__ Mitral Valve Prolapse	__ Tobacco Habit
__ Cancer	__ Headaches	__ Pacemaker	__ Tonsillitis
__ Chemical Dependency	__ Heart Murmur	__ Radiation Treatment	__ Tuberculosis
__ Chemotherapy	__ Heart Problems	__ Respiratory Disease	__ Ulcer
__ Circulatory Problems	__ Hemophilia	__ Rheumatic Fever	__ Venereal Disease

Medications

_____

_____

_____

In case of an emergency who should be notified? Name_____

Phone (____) _____ **Relationship** _____

_____ _____

Signature of Patient/ Parent/ Guardian or Authorized Representative **Date**

_____ _____

Printed Name of Patient/ Authorized Representative **Relationship/ Capacity to Patient**

HIPAA Authorization Form

Patient Name: _____ Birthdate: _____

CONTACT AUTHORIZATION:

This authorization form permits O'Neill Family Dentistry to contact you and/ or leave voicemails regarding your future appointments, results of tests or x-rays, and billing information. Please provide phone numbers that are acceptable to use for this communication.

Authorized Phone Numbers	Authorized Information
Home Phone: _____ Mobile Phone: _____ Business Phone: _____	☐ Appointment time ☐ Results of tests or x-rays ☐ Billing ☐ Other _____
☐ No one is authorized to leave a message concerning my personal information	
☐ I would like to opt out of receiving e-mail and text message appointment confirmations, reminders, marketing materials, account updates, and opportunities to provide feedback.	

DISCLOSURE AUTORIZATION:

This form gives O'Neill Family Dentistry authorization to release information regarding yourself covered under the Privacy Act to the following person(s) you list below.

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

☐ No one is authorized to receive my personal information.
NOTICE: This will leave you, as the patient, solely responsible for obtaining and redistributing any of your protected health information to any other medical, dental, or preferred office.

Rights of the patient: I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to O'Neill Family Dentistry. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient/Parent/ Guardian or Authorized Representative Date
(Guardian or Authorized Representative must attach documentation of such status)

_____ _____
Printed Name of Patient/ Authorized Representative Relationship/ Capacity to Patient

Policy Acknowledgement

Patient Agreement

In order to enhance your experience as a patient, we would like to have a clear understanding of the expectations of initiating and continuing care here at O'Neill Family Dentistry. It is our expectation that you, the patient, will participate and accept recommended treatment with the understanding that not doing so releases the Dr. and Hygienist from responsibility of lack of care. That you will keep and be on time for all scheduled appointments, understanding that coming more than 15 minutes past your appointment time may mean you are rescheduled. The Dr. and Hygienist will be notified of any changes in health or medications. The patient will keep up to date with any balance and notify us of any insurance/benefits change. The patient will treat and speak to all members of the staff respectfully at all times. It is understood that breaking any part of the agreements may mean dismal as a patient.

Financial Agreement

Payment is due **IN FULL** at the time of the service. As a courtesy to our patients with insurance, we will file your primary insurance. The **estimated** portion of the uncovered fees are due in full at the time of your appointment. After all insurance payments are made any remaining balance is the patient's responsibility, and will be billed to the patient. If for any reason payment is not made in 90 days a service charge of $25 will be added, and the family account will be **sent to collections**.

Confirmation Agreement

In order to be considerate of all of our patient's time and provide the quality dental care you desire we have set forth the following agreement. Thirty days prior to your dental appointment we will send you a reminder to the e-mail address on file. Two weeks prior to your appointment we will send you a confirmation text prompting you to confirm your upcoming appointment. All patients that have not confirmed will receive another confirmation text four days prior to your appointment. We will attempt to call all patients with unconfirmed appointments two days prior to your scheduled appointment. Your appointment is only considered confirmed when you communicate directly with our office via email, text or phone. If we have not received confirmation from you within 24 hours of the scheduled appointment, we reserve the right to release your appointment.

Cancellation Agreement

We require a 24-hour notice in order to cancel or reschedule an appointment without your account reflecting a charge for the visit. We reserve the right to charge your account for any appointment that is cancelled, rescheduled, or missed without a 24-hour notice. There will be a charge of $25.00 for every **hour** scheduled. Payment will be due in full at the patient's next visit.

_____ _____

Signature of Patient/ Parent/ Guardian or Authorized Representative | Date

_____ _____

Printed Name of Patient/ Authorized Representative | Relationship/ Capacity to Patient

Notice Of Privacy Practices
for the office of
O'Neill Family Dentistry
3224 Millwood Avenue
Columbia, SC 29205
(803) 988-1070

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information
for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

Authorized Uses or Disclosures

The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- Not applicable to this practice

Uses or Disclosures for Marketing Purposes- Not applicable to this practice

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may,
in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section.

Right of an individual to request a restriction of uses and disclosures
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

Confidential communication requirements
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information
An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information
An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information
An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

Right of Breach Notification
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice
You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our offices(s) and posted on our web site, if applicable.

Complaints

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is May 10, 2016

Acknowledgement of Receipt of
Notice of Privacy Practices
For
Dr. Kris Hilton
O'Neill Family Dentistry
3224 Millwood Avenue
Columbia, SC 29205
(803) 988-1070

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____

_____

Employee preparing document Date

_____

Employee signature _____